QUESTIONS AND ANSWERS REGARDING THE ISSUANCE OF A NOTICE OF ACTION (NOA)

Q1. What is a Notice of Action (NOA), and what is its purpose?

A1. A Notice of Action is a form given to a beneficiary when the MHP or its providers decide that a beneficiary is not entitled to any MHP services or when the MHP denies/ modifies a provider's request to provide specialty mental health services to the beneficiary. The purpose of the Notice of Action is to advise the beneficiary of the action and to provide information on the beneficiary's right to appeal the decision.

There are two types of NOAs: The NOA related to assessments, called the NOA-A, and the NOA for all other actions, called the NOA-B.

An NOA-A is used when the MHP or its providers assess a Medi-Cal beneficiary and decide the beneficiary does not meet medical necessity and no specialty mental health services will be provided.

Not meeting medical necessity means any of the following:

1) *That the beneficiary doesn't have a diagnosis covered by the MHP (an included diagnosis);*
2) *That a beneficiary who is 21 or over has an included diagnosis, but doesn't have a significant impairment;*
3) *That a beneficiary who is under 21 years of age has an included diagnosis, but there is no covered intervention that will correct or ameliorate the condition;*
4) *That the beneficiary has an included diagnosis, but the condition would be responsive to physical health care based treatment.*

An NOA-B is used when a provider requests to provide specialty mental health services on behalf of the Medi-Cal beneficiary, and the MHP denies, modifies, or defers (over 30 days) the provider's request. An NOA-B is also used when the MHP terminates or reduces services the MHP has already approved.

An NOA-BACK must be issued in conjunction with both the NOA-A and the NOA-B forms. The NOA-BACK contains important information about the beneficiary's appeal rights.

<u>NOTE</u>: The beneficiaries right to an NOA is independent of the beneficiary's right to request a fair hearing, to utilize the complaint or grievance processes, and, when applicable, to the right of a second opinion.

Q2. Are there special NOA forms that must be used?

A2. No, but certain information must be contained on the NOA-A, NOA-B, and NOA-BACK forms. The DMH has prepared forms that contain the necessary information. These forms (dated 7/98) can be obtained by contacting the DMH Technical Assistance and Training staff for your region. MHPs are welcome to personalize the forms as long as the necessary information is incorporated.

Q3. Have the NOA forms been translated into other languages?

A3. Yes. The DMH NOA forms are available in Armenian, Cambodian/Khmer, Chinese, Farsi, Hmong, Korean, Lao, Mien, Russian, Spanish, Tagalog, and Vietnamese. These forms can be obtained by contacting the DMH Technical Assistance and Training staff for your region.

Q4. Who receives a copy of the NOA?

A4. An NOA-A is given to the beneficiary. An NOA-B is given to the beneficiary with a copy to the provider. The MHP must keep a copy of all NOAs for its records.

Q5. Is the NOA still addressed to the beneficiary when the beneficiary is a minor?

A5. Yes, but a copy should also be sent to the parent or legal guardian.

Q6. When do I give the NOA to the beneficiary?

A6. With exceptions, the NOA, at the election of the MHP, must be hand delivered or put in the mail no later than the third working day after the action was taken.

The most common exceptions include:

1) *Within one working day when the beneficiary is in a psychiatric inpatient hospital;*
2) *At least 10 calendar days before the effective date of action when the MHP elects to reduce or terminate authorization it already approved.*

(See Title 22, California Code of Regulations, Section 15014.1, for additional exceptions.)

Q7. What are Specialty Mental Health Services?

A7. Specialty Mental Health Services include:

a) Rehabilitative Mental Health Services, which include:

1) mental health services,
2) medication support services,
3) day treatment intensive,
4) day rehabilitation,
5) crisis intervention,

6) crisis stabilization,
7) adult residential treatment services,
8) crisis residential services,
9) psychiatric health facility services

b) Psychiatric Inpatient Hospital Services
c) Targeted Case Management
d) Psychiatrist Services
e) Psychologist Services
f) EPSDT Supplemental Specialty Mental Health Services

Q8. Must an NOA be issued when a network provider does an assessment and determines the beneficiary does not meet medical necessity?

A8. Yes. The beneficiary must be provided an NOA-A regardless of whether the assessment is completed by the MHP or its providers. The NOA-A itself may be provided to a beneficiary by the provider or by the MHP.

Q9. Must an NOA be issued when a beneficiary calls for general information about MHP services?

A9. No, if only general information about available services is discussed.

However, an NOA-A would be required if some sort of screening takes place and, as a result, it is determined that the beneficiary does not meet medical necessity. The MHP and its providers need to be very careful in this area. A caller to the toll-free access number or to an MHP provider should not be hastily turned away just because the caller mentions alcohol or substance abuse problems. It is strongly recommended that, when in doubt, a face-to-face assessment should be arranged.

Q10. Must an NOA be issued when a provider calls for general information about MHP services?

A10. No, if only general information about the services covered by the MHP and its authorization processes are discussed.

Q11. What if the MHP is unsure if an NOA should be issued?

A11. MHPs should use their best judgement regarding the requirements for issuing NOAs, but should resolve doubts in favor of providing an NOA. Assistance is available from DMH Technical Assistance and Training staff.

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Q12. If a beneficiary requests an assessment, can the MHP deny that request?

A12. An MHP must assess a beneficiary who requests an assessment or otherwise seeks assistance from the MHP. The MHP has an obligation to determine if medical necessity criteria are met for each beneficiary requesting assistance. DMH strongly recommends that this determination be made through a face-to-face assessment.

Q13. What form is used when a provider assesses a beneficiary, determines there is medical necessity, and the MHP denies the provider's request for authorization of services?

A13. An NOA-B because an NOA-B is related to a request by a provider.

Q14. Must an NOA be issued every time a beneficiary requests a service that the MHP has decided is not medically necessary?

A14. No. The MHP has to issue an NOA-A to a beneficiary after an assessment has been completed, and it is determined that the beneficiary is not eligible for any specialty mental health service from the MHP.

The MHP or its providers are responsible for determining what services the beneficiary needs. The MHP should ensure that services, to the extent possible, are client directed. A beneficiary who believes additional services are necessary has the right to challenge the MHP and its providers' decisions through the MHP's beneficiary problem resolution processes and the state fair hearing process.

When an NOA is not required in a potential dispute between a beneficiary and a provider (including MHP staff), it is critical that information about beneficiary problem resolution processes and fair hearings be available at the provider site as required by Title 9, CCR, Section 1850.205.

Q15. Must an NOA be issued if the provider requests individual therapy and the MHP approves group therapy?

A15. Yes. The MHP has modified the provider request and an NOA-B is required.

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Q16. When an MHP requires organizational providers (county and contract) to receive prior approval/authorization for services through a point of authorization process, are these decisions subject to the NOA-B requirements?

A16. Yes. The denial, modification, reduction, termination, or deferral of a request for authorization of a service request applies equally to individual, group, and organizational providers.

Q17. Regarding the NOA-B requirements, what is the difference between a treatment team providing clinical direction and the point of authorization (POA) process?

A17. Clinical supervision is really part of a "treatment team" approach to the determination of the beneficiary's mental health needs. In effect, the treatment team is the provider. Unless the MHP has specified that the clinical supervisor must make payment authorization decisions, clinical supervision is not an authorization process.

The POA process is subject to the NOA-B requirements.

NOTE: The above is only relevant to the NOA-B requirements. Both the treatment team and the POA are subject to the NOA-A requirements.

Q18. Must an NOA be issued when an MHP provider determines that a reduction or termination of services is needed?

A18. No, since the reduction or termination is being made by the provider rather than the MHP's point of authorization. NOA requirements don't apply to direct clinical decision-making. However, the beneficiary still has the same appeal rights as if the beneficiary were given an NOA.

Q19. Must an NOA be issued when prior authorization is not required for the first few visits, but is required after that, and the MHP denies the provider's request for additional services?

A19. Yes, an NOA-B must be issued. If the beneficiary files a timely request for a state fair hearing, there may also be a requirement to continue services pending the outcome of the hearing.

Q20. Must an NOA be issued when the MHP modifies the provider's request by approving a shorter time frame?

A20. *No, as long as the MHP provides an opportunity for the provider to request reauthorization prior to the expiration of the time approved and as long as the shorter time doesn't change the underlying treatment plan. For example, the provider requests 12 visits over 6 months and the MHP approves 6 visits over 3 months (a treatment plan of two visits a month could continue under either authorization). If the additional services are subsequently requested and not approved at that time, the beneficiary would then receive an NOA-B.*

Q21. Can an MHP simply issue an NOA when it doesn't provide a particular specialty mental health service the beneficiary needs?

A21. *No. If the MHP determines the beneficiary is in need of a particular specialty mental health service, it has an obligation to provide or arrange for that service. The issuing of an NOA does not excuse an MHP from meeting its contractual obligation to provide medically necessary specialty mental health services to its beneficiaries.*

Q22. Must an NOA be issued if the MHP offers a specialty mental health service, but not necessarily the service requested by the beneficiary?

A22. *No. However, the beneficiary must participate in the development of the client plan. The MHP should ensure that services, to the extent possible, are client directed. A beneficiary who believes additional services are necessary has the right to challenge the MHP and provider decisions through MHP beneficiary problem resolution processes and the state fair hearing process.*

Q23. Must an NOA be issued when an MHP approves the delivery of a specialty mental health service, but doesn't approve that it be delivered by the beneficiary's choice of provider?

A23. *No. However, the MHP must have a process for reviewing and, when feasible, approving a beneficiary's initial choice of provider or subsequent request for a change of provider.*

Q24. Must an NOA be issued when a provider leaves the provider network, but the MHP approves the continuation of services by a different provider?

A24. *No, as long as the beneficiary continues to receive the same type and level of services. The MHP, however, should provide reasonable notice to the beneficiary about the change.*

Q25. Must an NOA be issued when the beneficiary is not approved for a service he/she has requested?

A25. *No, unless the MHP determines that no specialty mental health services will be provided. (See related Q & A #22.)*

Q26. Must an NOA be issued when the beneficiary's day treatment program is reduced from five days/week to three days/week, or from intensive to rehabilitative, or from full day to half-day?

A26. *Yes, if the change was made by an authorization agent of the MHP.*

Yes, if the treatment team was acting as the MHP's payment authorization function.

No, if the change was the result of a clinical decision by the treatment team and the day treatment program has not requested payment authorization from the MHP's designated authorization function. Generally, if the day treatment program were represented on the treatment team, DMH would consider the decision-making process to be clinical.

Q27. Can an MHP refuse to complete an assessment on a beneficiary who asks for a service that is clearly not a specialty mental health service? And, must an NOA be issued?

A27. *When a beneficiary asks the MHP for a specific service that is clearly not covered by Medi-Cal, an assessment would not be required. Examples might include a request for marital counseling not linked to mental illness or a request for substance abuse treatment when the beneficiary identifies the diagnosis as a substance abuse disorder. However, an MHP might have a hard time defending itself if the beneficiary has problems downstream based on a mental illness that does meet medical necessity criteria. When in doubt, an MHP is encouraged to complete or offer to complete an assessment.*

Q28. How long and what types of services can be claimed to Medi-Cal prior to a determination of medical necessity?

A28. *In an urgent, crisis, or emergency situation, the MHP can/should provide whatever services are needed prior to establishing that all medical necessity criteria are met. If not an urgent, crisis, or emergency situation, the MHP should only claim those assessment services necessary to establish medical necessity.*

It is understood that MHPs have established 30-90 day intake periods during which time the provider is to establish medical necessity, set up the client plan, and coordinate the arrangement of necessary services. However, the intake period is not exempt from the medical necessity requirements for claiming Medi-Cal. Once it has been established that the beneficiary does not meet medical necessity criteria, an NOA-A should be issued and Medi-Cal claiming discontinued.

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Q29. How long can it take to determine medical necessity?

A29. As long as necessary.

Q30. Must an NOA-A be issued if a treatment team determines a lack of medical necessity?

A30. Yes, an NOA-A is required for decisions by the MHP or its providers. The treatment team, acting as a provider, is deciding that the beneficiary will not receive services from the MHP.

Q31. Must an NOA be issued if a treatment team discusses/assesses a beneficiary's need for additional services, e.g., day treatment, but decides that the service is not needed?

A31. No, if the treatment team is making a clinical decision about the need for services that the team will arrange for or provide to the beneficiary.

Yes, if the treatment team is making an authorization decision about the necessity for services requested by another provider, whether the request is made verbally or in writing.

Q32. Must an MHP have an authorization process in place for all services other than psychiatric inpatient hospital services?

A32. No. The MHP only needs to assure that all services are provided under the direction of a physician, licensed/registered/waivered psychologist, licensed/registered/waivered social worker, licensed/registered/waivered marriage and family therapist, or a registered nurse.

Q33. Must an NOA-A be issued when a beneficiary, who originally asked for services, changes his mind during the assessment process and, as a result, no services were offered?

A33. No, assuming the decision that services are not necessary was made by the beneficiary. The trigger for an NOA-A is the decision by the MHP or its providers that no services are needed. When the MHP or its providers explain to the beneficiary why no services are needed and the beneficiary then agrees, an NOA-A is required.

Q34. Must an NOA-A be issued when the MHP completes an assessment of a beneficiary at the request of a third party, and the MHP determines the beneficiary does not meet medical necessity?

A34. Yes. An NOA-A is required whenever the MHP determines the beneficiary lacks medical necessity for services, regardless of the source of the referral to the MHP.

Q35. Would an NOA be required when the MHP or its providers determine the beneficiary needs Crisis Residential services, but the facility is full?

A35. No. If the MHP determines the beneficiary is in need of a particular specialty mental health service, it has an obligation to provide or arrange for this service. The issuing of an NOA is does not excuse an MHP from meeting its contractual obligation to provide medically necessary specialty mental health services to beneficiaries. It's about access, not the NOA.

Q36. Must an NOA-A be issued following an assessment for crisis evaluation or for admission into an inpatient facility when the beneficiary is denied admission?

A36. No, assuming the crisis intervention only involves assessment of the crisis and treatment to resolve the crisis as appropriate.

A crisis intervention is typically about resolving a crisis, not about determining MHP medical necessity. An NOA-A would be required only when an assessment determined that medical necessity has not been met for any future specialty mental health service. If the crisis intervention provider does make a determination that the beneficiary does not meet medical necessity for future services, an NOA-A would be required.

When a beneficiary is denied admission to a hospital or psychiatric health facility, an NOA-A is not required. The requirement to provide an NOA-A does not apply to determinations that a beneficiary does not meet the medical necessity criteria for psychiatric inpatient hospital services or psychiatric health facility services (see Title 9, CCR, Section 1850.210(i).

Q37. Does the MHP have to provide a specialty mental health service it doesn't offer?

A37. The MHP has to provide whatever service it determines meets the beneficiary's needs. For example, if the MHP determines day treatment is needed, it must provide the service. If the MHP determines that targeted case management and intensive mental health services are needed, it must provide this intensive level of services. Issuing an NOA does not absolve the MHP of its obligation to provide the specialty mental health service(s) the MHP found to be necessary.

Q38. Our county routinely evaluates all admissions to its county children's home to determine the need for mental health services. The assessment tool has a number of questions with each question being assigned a point value. Specialty mental health services are provided or not provided based upon the total number of points accumulated. In most cases neither the beneficiary nor the legal guardian asked for this evaluation. Must an NOA-A be issued if no services are offered?

A38. Yes, because the evaluation tool is being used as an assessment tool to determine eligibility for specialty mental health services. It's irrelevant who asked or didn't ask for the evaluation once the MHP or its providers decide to complete an evaluation.

Q39. At the request of Adult Protective Services, county staff routinely evaluate seniors in their homes to determine the need for mental health services. Based upon this evaluation, some are found eligible for services; others are not. Is an NOA-A required if no services are offered?

A39. Yes, because the evaluation tool is being used to determine eligibility. It's irrelevant who asked or didn't ask for the evaluation once the MHP or its providers decide to complete an evaluation.

Q40. Our county utilizes treatment teams for determining what services will be offered to beneficiaries of organizational providers. However, membership on these teams is limited to MHP owned and operated organizational providers. Non-MHP provider services are utilized for specialty services not available from MHP providers, e.g., adult residential and day treatment. The MHP treatment teams decide when to refer the beneficiary to a non-MHP provider and when to discontinue services with that provider. Must an NOA-B be issued when the treatment team denies or discontinues services from that provider? What if the non-MHP provider was a member of the treatment team?

A40. Yes, if the treatment team was acting as the MHP's payment authorization function and the "outside" service provider requested payment authorization either verbally or in writing.

No, if the change was the result of a clinical decision by the treatment team and the provider of the "outside" service has not requested payment authorization from the MHP's designated authorization function. Generally, if the "outside" service provider is represented on the treatment team, DMH would consider the decision-making process to be clinical.

Q41. Is an assessment to determine medical necessity considered a specialty mental health service? In particular, if a beneficiary is found to not meet medical necessity criteria after a few assessment sessions or by the end of the 30-90 day intake period, does the MHP need to issue an NOA-A?

A41. *Yes, the MHP needs to issue an NOA-A, if a beneficiary is found not to meet medical necessity after a few assessment sessions or by the end of a 30-90 day intake period.*

An assessment to determine medical necessity is a specialty mental health service covered by the MHP. A beneficiary does not need to meet medical necessity to receive such an assessment. (See Title 9, CCR, Section 1810.345.) The NOA-A applies to a determination that future services will not be provided because the beneficiary being assessed does not meet medical necessity.

Q42. Our MHP allows providers to claim for several sessions without prior authorization. These sessions could be assessment or treatment related. Does the MHP need to issue an NOA-A if the provider doesn't ask for any more sessions?

A42. *Yes, if the assessment resulted in the beneficiary being found ineligible for services. Except in urgent, crisis, and emergency situations, no treatment services should be claimed to Medi-Cal until such time medical necessity has been established.*

No, if the beneficiary was found to meet medical necessity and the provider believes the beneficiary received all the services needed to meet the beneficiary's needs at this time.

Q43. Does the MHP have to provide an NOA when TBS services are denied? If yes, is the NOA-A or NOA-B form used?

A43. *Yes, all the same NOA rules apply. If a provider requests payment authorization for TBS and the MHP denies the request, an NOA-B is required. If a beneficiary or the beneficiary's parent of legal guardian requests TBS, and the MHP's assessment as a result of this request is that the beneficiary doesn't meet medical necessity for any MHP services, an NOA-A would be required. In addition, the terms of the permanent injunction in Emily Q vs. Bonta (the lawsuit that established TBS), the MHP must send a copy of each TBS-related NOA to DMH.*

Q44. Our county has embarked on a concurrent authorization review process for all organizational providers. This is not about the treatment team making decisions about the course of treatment, and it's more than a point of authorization (POA) *advising* the clinic team on service parameters.

In this case the treatment team makes its request for services to the MHP's POA, and the POA acts independently of the treatment team. Must an NOA-B be issued when the POA denies services requested by the treatment team? What if the POA is only acting as an advisor to the treatment team?

A44. *Yes, if the POA is making a decision about whether or not the MHP will claim FFP for the service and if a denial decision means the POA has determined that the service isn't billable for FFP (whether or not this means the service will not be delivered). The decisions that are exempt from NOA-B requirements are decisions based purely on clinical judgment and reimbursement decisions that are made retrospectively (i.e., the beneficiary already received the service).*

No, if the POA is only advising the treatment team. However, be careful, it's a fine line between acting as the POA and acting as an advisor on countywide treatment standards.

Q45. Regarding TBS, can an MHP screen out referrals without giving an NOA?

A45. *Yes, but only when the beneficiary is 21 years of age or older or the beneficiary is not full-scope Medi-Cal, e.g., a beneficiary eligible only for minor consent services or for emergency and pregnancy related services.*

Q46. Must an NOA be issued when the beneficiary, parent of the child, a guardian, or a non-provider referral agency, such as probation, school, or Social Services, requests TBS and the MHP denies the request?

A46. *The MHP is not required to issue an NOA when the MHP denies a request for TBS from someone other than the provider that will be delivering or arranging for the service, e.g., a contract organizational provider or MHP clinical team. An MHP, however, may not deny a request for TBS from a beneficiary or the beneficiary's representative unless the beneficiary has been assessed by the MHP and determined not to meet the criteria for TBS.*

The beneficiary or authorized representative still has the right to request a state fair hearing and to access the MHP's beneficiary problem resolution process.